Name:_____ **Date of Birth:**_____

Diagnosis:_____

Allergies:_____

Medications:_____

Today's Date:_____ **Form Completed By:**_____

Please answer the following questions about your health and development so we can help with your needs.
(YOU always refers to the YOUNG PERSON)

Staff Only F/U	**Health Questions** **Medical Home:**_____	**YES**	**SOME -TIMES**	**NO**
	1. Do you have a medical home (family doctor or clinic) that you go to when you are sick or need a check-up?			
	2. Do you have regular check-ups with your medical home provider?			
	3. Are your immunizations up-to-date?			
	4. Do you feel that your general health is good?			
	5. Do you know when, how much, and why you take medications? (prescription and over-the-counter, like Tylenol)			
	6. Are you able to get the medications, therapy, supplies, and/or equipment you need?			
	7. Are you independent in your personal care?			
	8. Do you have friends that you spend time with at least once a week?			
	9. Have you thought about what you would like to do when you become an adult?			

Name:_____ ID #: _____

Information You Would Like to Have:

- ❍ Assistance Programs
- ❍ Medicaid
- ❍ Social Security
- ❍ Transportation
- ❍ Counseling
- ❍ School Plans
- ❍ Sexual Development
- ❍ Independent Living
- ❍ Careers
- ❍ Colleges
- ❍ Scholarships
- ❍ Vocational Rehabilitation

COMMENTS:_____

STAFF USE ONLY:_____

Reviewed By:

Initials	Signature	Date